State of Washington 2017-6985

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60429197	A. BUILDING: _____ B. WING _____	C 07/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS STATE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 WAC Private Psychiatric and Alcoholism Hospitals Licensing Regulations, conducted this health and safety complaint investigation. Onsite dates: 7/25/17 Examination number: 2017-6985 Intake number: 74246 The investigation was conducted by: Deborah Barrette, RN There were violations found pertinent to this complaint.	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number. HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed (Must be completed within 60 days of the survey exit date) 3. Your PLANS OF CORRECTION must be returned within 10 working days from the date you receive the Statement of Deficiencies. Your plan of correction must be postmarked by August 11, 2017. 4. Return the ORIGINAL REPORT with the required signatures. The administrator or representative's signature and date are required on the first page and initials in the lower right hand corner on the remaining pages of the report.	
L 320	322-035.1D POLICIES-PATIENT RIGHTS WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and	L 320		9/25/17

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L 320	Continued From page 1 services provided: (d) Assuring patient rights according to chapters 71.05 and 71.34 RCW, including posting those rights in a prominent place for the patients to read; This Washington Administrative Code is not met as evidenced by: Based on interview and record review the facility failed to provide a patient (Patient #1) with a copy of "Patient Rights and Responsibilities" upon admission to the facility. Failure to provide the patient with a copy of their patient rights and responsibilities potentionally places patients at risk for abuse, neglect or unmet care needs. Findings inclIude: 1. Review of Patient #1's "Consent to Treat" record on 6/7/17 revealed the patient was not provided "Patient Rights & Respnsibilites" Information upon admission. 2. The above information was verified with Staff D (Risk Manager) on 7/25/17 at 12:00 PM. Staff D stated patients should be given a copy of their rights and responsibilities upon admission.	L 320		
L1040	322-170.1C TRANSFER PATIENTS WAC 246-322-170 Patient Care Services. (1) The licensee shall: (c) Provide appropriate transfer and acceptance of a patient needing medical care services not provided by the hospital, by: (i) Transferring relevant data with the patient; (ii) Obtaining written or verbal approval	L1040		9/25/17

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L1040	Continued From page 2 by the receiving facility prior to transfer; and (iii) Immediately notifying the patient's family. This Washington Administrative Code is not met as evidenced by: Based on interview, record review, and review of facility policies/procedures the facility failed to immediately notify a patient's (Patient #1) family when the patient was transferred to another hospital due a change in the patient's medical conditon. Failure to notify family may cause a delay in the patient receiving the proper medical care in an appropriate time interval. Findings include: 1. The policy titled "Change in Condition" last reviewed January 2017. Stated under "VII. Notify family of resident's condition/transfer/pending transfer. Document that family was notified; who was notified, date and time". 2. Review of the patient's medical record revealed on 6/8/17 at 2:00 PM at the time the patient was being transferred to another hospital for a higher level of care it stated " Patient did not name a family member member or friend to notify". 3. A contact for Patent #1 was interviewed by the surveyor on 7/13/17 at 10:46 AM. The contact stated the family was not made aware of the transfer of Patient #1 until the next day. 4. On 7/25/17 at 11:00 Staff A (Registered Nurse) was interviewed. Staff A stated that family always needed to be notified when a patient had	L1040		

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L1040	Continued From page 3 a change in their medical condition and was being transferred to another facility for a higher level of care. 5. The above information was verfied with Staff B (Chief Nursing Officer) on 7/25/17 at 11:20 AM.	L1040		
L1065	322-170.2E TREATMENT PLAN-COMPREHENS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (e) A comprehensive treatment plan developed within seventy-two hours following admission: (i) Developed by a multi-disciplinary treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition; (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan; This Washington Administrative Code is not met as evidenced by: Based on interview, record review, and review of facility policies and procedures that facility failed to review and collaborate pertinent information between the nursing admission assessment to the admitting physician doing the admission history and physical for a patient (Patient #1). Failure to share information from the admission	L1065		9/25/17

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L1065	Continued From page 4 nursing assessment may potentially cause a delay in a patient's medical treatment and care. Findings include: 1. The facility policy titled "Assessment/Reassessment" stated "All patients admitted to the hospital will receive a thorough assessment and evaluation. Results of the assessments are reviewed to determine treatment needs (s) of the client and prioritized within the Interdisciplinary Treatment Plan". 2. The Patient #1 was admitted to the facility on 6/7/17. The nursing admission assessment done on 6/7/17 stated the patient had a history of falls at home. The admission assessment asked about the frequency of falls this was left blank with no clarification documented. The next question asked was medical attention received for a recent fall and this was left blank. 3. The patient's admission history and physical done by the attending medical practitioner on 6/7/17 did not mention a review of the nursing assessment. 4. On 6/8/17 Patient #1 was transferred to another facility for a higher level of care after becoming lethargic and difficult to arouse. Records reviewed from the accepting facility revealed the patient had a subdural hematoma. No facial eccymosis was noted on the exam to suggest a recent fall. During the assessment of the patient in the emergency room the patient reported a recent fall but did not recall the date. 5. Review of the discharge summary for the facility dated 6/8/17 revealed the patient was admitted on 6/7/17 to the facility for alcohol detox	L1065		

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L1065	Continued From page 5 treatment. On 6/8/17 the patient was transferred to another facility for a higher level of care after becoming lethargic and difficult to arouse. The discharge summary stated the patient was admitted for a "subdural hematoma". "The patient never disclosed to all that she had a fall before she came to our facility, which is most likely the cause of her subdural hematoma". 6. On 7/25/17 at 11:35 Staff C (Registered Nurse) was interviewed. The nurse stated information obtained by the nursing assessment should be reviewed by the medical practitioner as part of the patient's comprehensive history and physicial. 7. On 7/25/17 12:00 PM the above information was verified with Staff D.	L1065		